

STATE OF MISSOURI DEPARTMENT OF MENTAL HEALTH NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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(client, guardian, or parent of minor client)					
acknowledge that I have received the Notice of Privacy Practices with an					
effective date of April 14, 2003.					
Signature of client, guardian, or parent of minor client:	Date:				
ellite.					
STATE OF MISSOURI DEPARTMENT OF MENTAL HEALTH APPLICATION FOR SUPPORTIVE COMMUNITY LIVING SERVICES					
I,					
(client, guardian, or parent of minor client)					
make application for(client)					
to receive Supportive Community Living services.					
I authorize my* referral to appropriate community residential facilities. I also authorize the release of information about me* to those community residential facilities in order to determine if those facilities will consider accepting me*. I understand that any facility at which placement is made is inspected and licensed by the Missouri Department of Mental Health and/or the Missouri Department of Health and Senior Services. I understand that I have the right to visit the facility prior to placement, and that I can refuse placement at any specific residential facility.					
I understand that I* or a responsible party, if any, is responsible to support and maintain me* based on ability to pay. I understand that all earned or unearned income and other assets of mine* must be reported to the regional Supportive Community Living program and that I* or a responsible party may be required to pay part or all of these assets for my* care. Assets include SSDI and SSI back payments. Care for those months covered by the back payment will be charged to me* or my* responsible party.					
If I* will be living in an apartment, I authorize disclosure to the landlord that I* am a client of the Department of Mental Health.					
* For a guardian or a parent of a minor client, the words '1," 'me," 'my," or 'mine" refer to the client, where indicated.					
Signature of client, guardian, or parent of minor client:	Witness:				
Date:	Witness:				